TRANSITION CASE FOR CHANGE

PROPOSAL FOR CLINICAL COMMISSIONING IN COVENTRY & WARWICKSHIRE

Abstract

This document aims to outline the Case for Change for the future working arrangements of NHS Coventry & Rugby Clinical Commissioning Group (CCG), NHS South Warwickshire CCG, and NHS Warwickshire North CCG, currently acting as commissioning partners in the Coventry & Warwickshire Sustainability and Transformation Partnership (STP)
It describes the context and identifies the engagement feedback and overall narrative for the process of considering the options for change. It recommends a preferred option. It also includes information addressing the 11 tests required by NHS England for mergers of CCGs as defined in April 2019.

It is drafted for an intended audience of high-level, informed stakeholders.

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DOCUMENT HISTORY COVER SHEET

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7	22.05.19	LM	Correction to total number in figure 2, p9

Table of Contents

1. Introduction

The NHS Long Term Plan (LTP) was released in early January 2019. Of note for the local population is the requirement for a plan to address local health inequalities, and clarity of a new service model for the NHS. This new model will comprise of Primary Care Networks (PCNs), facilitated by a new type of General Medical Services (GMS) network contract. Every Sustainability and Transformation Partnership (STP) area in the country is to be, or be part of, an Integrated Care System (ICS) by 2021.

With less than two financial years to deliver this change, discussions have centred around the development of the local PCNs and the transition of the three individual clinical commissioning groups (CCGs) to a single strategic commissioner as required by the LTP. This has led to several scenarios for strategic commissioning being put forward which are explained in this document. Proposals for PCNs and updated Primary Care Strategy are the subject of other documents.

This document describes current challenges and commissioning arrangements and sets out the thinking for changing the way the CCGs could work together in the future to underpin the transition into an ICS. It explains the possible alternative options; including their advantages and disadvantages.

Governing Body members are asked to discuss the options set out in this paper and the recommendation of the option which will best fit and most rapidly begin to deliver the requirements of the LTP within the timescale required nationally. The approved recommendation will be put to a vote of the members in line with the required constitutional arrangements for each CCG.

2. Background

The NHS Long Term Plan (LTP) sets out an intention to continue to develop Integrated Care Systems across England and that, by April 2021, ICSs will cover the whole country. NHS England describes an ICS as an arrangement in which NHS organisations, in partnership with local councils and others, take collective responsibility for planning and commissioning care, managing resources, delivering NHS standards, and improving the health of the population they serve.

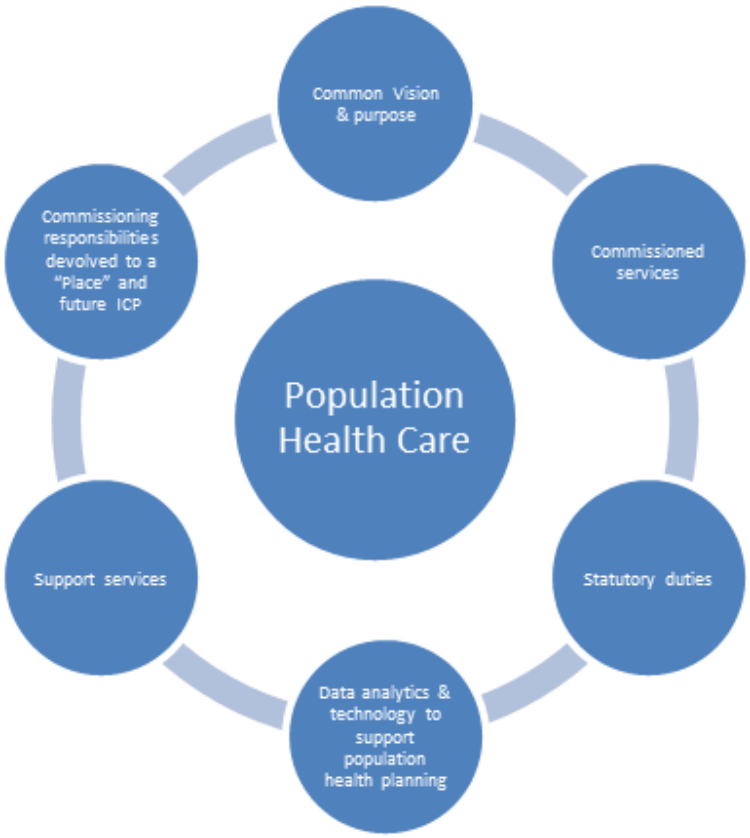

Figure 1: Population Health Care delivery

The LTP (p.29) describes how the commissioning environment will continue to evolve and that it is in this context that CCGs will operate in future.

> '*Each ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.'*

Across England there is a growing appetite for formal CCG mergers. Several, for example in Birmingham & Solihull and around Bristol, became new statutory bodies on 1 April 2018. This reduced the total number of CCGs from 211 in 2013 to 195 in 2018. The drive and ambition to respond is leading to rapid change with many other CCGs implementing new structures by

1 April 2020. Many have already set up shared management teams and innovative structures across STP areas to help tackle the issues they face and facilitate the shift from competition to collaboration.

A range of solutions are being implemented around the country from:

- formally merged CCGs,
- further integration with local government,
- smaller Place-based systems involving commissioners and providers in a Place and providers taking on commissioning responsibilities.

No 'one size fits all' approach is mandated by NHS England.

The ICS needs health commissioning to change to support development of two critical capabilities:

- Better, faster service integration by better alignment of commissioning resources e.g. pathway redesign, contracting expertise, case management etc. with providers around discreet populations known as a 'Place';
- Streamlined, single commissioning resources for a population approach focusing on assurance, financial management, strategic change, and outcomes-based commissioning. CCGs have been told, by NHS England, to reduce their running costs by 20% as part of these new structures by 2020/21

In the future, the strategic commissioners will contract with a single organisation or partnership of organisations to manage a single budget and deliver a range of services for the local population, focusing on the population's health and wellbeing. This means that CCGs will have a more strategic role in overseeing the local health system, focusing more on overall performance and less on individual services. Providers will take on delivery commissioning currently carried out by commissioners, such as sub-contracting for and monitoring the performance of individual services.

Commissioners identified a number of scenarios for the future of health commissioning across Coventry and Warwickshire, and criteria against which to assess them. These have been tested with staff and stakeholders to inform selection and weighing of the assessment criteria, the preferred option and the case for change that is the subject of this paper.

To make this transition successful, there are several important factors to consider:

- What is already in place that demonstrates working in the ICS way;
- What, and where, are potential opportunities for this change to further benefit patients and the public, improving population health through integration, and/or to address inefficiencies or financial challenges;
- Full assessment of the risk vs benefit of potential changes; and
- Availability of the resource required to achieve the changes in an appropriate timescale.

3. The CCGs

The local CCGs were formed in April 2013 taking over responsibility for planning, paying for, and monitoring, local health services from Primary Care Trusts (PCTs). These were new organisations combining the expertise of local family doctors and NHS managers putting local doctors and nurses at the heart of deciding which health services to provide, and where and

how they would be provided.

Each CCG is led by a Governing Body. All general practices in a CCG area are members of that CCG and have clinical representatives elected to their respective governing bodies. The CCG membership retains the authority to set the strategy and direction for the organisation and to hold their governing body to account.

CCGs are responsible for commissioning services including:

- Planned hospital care
- Rehabilitative care
- Urgent and emergency care (including out-of-hours)
- Most community health services
- Mental health and learning disability services.

The CCGs also have delegated authority from NHSE for commissioning general practice primary care services.

The three CCGs have a long history of working together to commission hospital, community, children's and mental health services working in partnership with social care.

4. CCG profiles

NHS Coventry & Rugby Clinical Commissioning Group

Accountable officer: Andrea Green
Address: Parkside House, Quinton Road, Coventry, CV1 2NJ
Local authority: Coventry City Council (for Coventry)
Warwickshire County Council (for Rugby)
2019/20 budget: £729.4 million
Number of staff: 256 (this includes several directly provided services)

NHS South Warwickshire Clinical Commissioning Group

Accountable officer: Gillian Entwistle
Address: Westgate House, Market Street, Warwick, CV34 4DE
Local authority: Warwickshire County Council
2019/20 budget: £404 million
Number of staff: 52

NHS Warwickshire North Clinical Commissioning Group

Accountable officer: Andrea Green
Address: Heron House, Nuneaton, Newdegate Street, Nuneaton, CV11 4EL
Local authority: Warwickshire County Council
2019/20 budget: £282.7 million
Number of staff: 53

The total GP registered list sizes at 1 January 2019 of 813,954 are located across the four Place areas as set out in the table below.

Place	Registered Population	Primary Care Networks	GP practices
Coventry	411,972	7	56
Rugby	110,691	1	12
South Warwickshire	291,291	7	33
Warwickshire North	192,278	4	26
Total	**1,006,232**	**19**	**127**

Figure 2: GP registered list size by 'Place'

Registrations grew during 2018 by 2% in each of Coventry, Rugby and South Warwickshire Places; and 1% in Warwickshire North.

In April 2017, NHS Coventry & Rugby CCG and NHS Warwickshire North CCG became jointly managed organisations with a single executive team and reduction in duplication through a single finance and commissioning function. The CCGs remain distinct and separate bodies constitutionally, with separate chairs and lay members, but holding Committees-in-Common for all Governing Body and statutory committees other than the Primary Care Committees, which are Place-based.

The LTP proposes that typically a population of this size (approx. 1m) would be covered by a single strategic commissioner (see diagram) and also that the current Sustainability and Transformation Partnerships (STPs) will be used as the geographical basis for future ICSs.

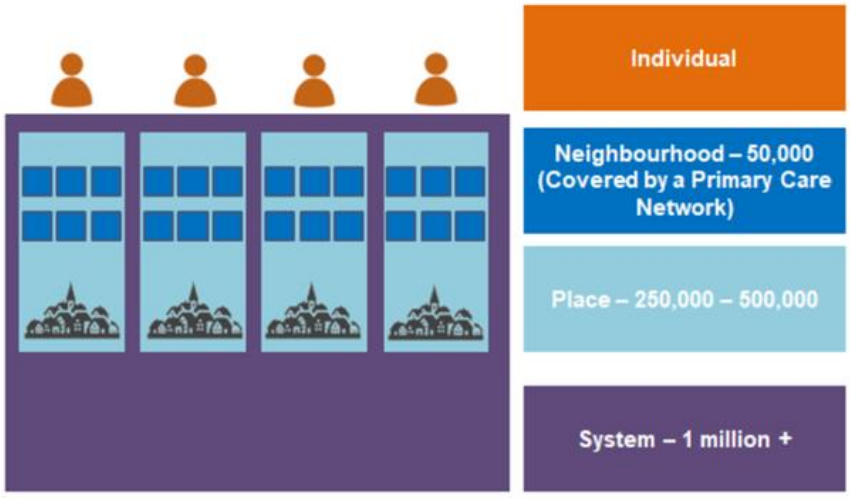

Figure 3: Layers of an Integrated Care System

5. Current joint working arrangements in relation to contracts and services

The area includes three acute hospitals, one of which also provides several specialised services commissioned directly by NHS England; a partnership trust providing core mental

health services for the whole population and community services in Warwickshire operated by one of the acute trusts; and 127 general medical practices, serving a total of approximately 960,000 local residents.

- University Hospitals of Coventry & Warwickshire: general and tertiary (specialised) acute
- George Eliot Hospital: general acute
- South Warwickshire Foundation Trust: general acute and Out of Hospital services for Warwickshire
- Coventry & Warwickshire Partnership Trust: Mental Health and Learning Disability plus Out of Hospital services for Coventry.

Figure 4: Location map

- NHS Coventry & Rugby CCG is the co-ordinating commissioner for UHCW and CWPT and leads negotiations on behalf of all 3 CCGs. It carries out activity analysis and raises challenges on behalf of all 3. It also hosts the IFR team and management of the commissioning policies reform group.

- NHS South Warwickshire CCG is the co-ordinating commissioner for SWFT and leads negotiations on behalf of all 3 CCGs for the trust's acute and other Warwickshire-wide services, including the Out of Hospital contract. The CCG is also lead commissioner for Out of Hours services.

- NHS Warwickshire North CCG is the co-ordinating commissioner for the George Eliot Hospital Trust and other Warwickshire-wide services.

- The Arden-Gem Commissioning Support Unit (CSU) provides services to all three CCGs:

Information Governance, Communications & Engagement, Business Intelligence (DSCRO) and other functions such as HR, estates and information technology. The CCGs vary in their utilisation of these services with Coventry & Rugby commissioning fewer services than the other two.

- West Midlands Ambulance Service NHS Foundation Trust; NHS 111 are contracted by Sandwell and West Birmingham CCG as the co-ordinating commissioner for the area consortium. The staff who manage this process are funded by the three CCGs.

- The CCGs have experience of working together on joint 'at scale' procurements, namely: Any Qualified Provider (AQP) and CSU procurements.

6. Local population

The area of Coventry and Warwickshire is home to a population with wide and diverse needs together with areas of rurality and urban conurbations. Despite the focus of population within the main towns of the county, a significant part of Warwickshire is rural in nature.

In the past ten years, Coventry's population has grown by a fifth, making it the second-fastest growing local authority outside of London. In 2016-17 its growth rate was the seventh highest. Growth is particularly high amongst 18-29 year olds.

The county of Warwickshire has five Districts. The larger population bases are Nuneaton & Bedworth, Stratford-on-Avon and Warwick. Nuneaton & Bedworth is an area of significant urban deprivation, being some of the most deprived in the country. The North Warwickshire District is a more rural area. The Nuneaton & Bedworth and Stratford-on-Avon Districts have experienced the largest numerical population increases, with North Warwickshire, Warwick and Rugby Districts experiencing much lower, but approximately the same numerical increases as each other. Generally, the rate of population growth in the county of Warwickshire is below that experienced nationally (0.83%) but there is variation between the five districts.

	Population / Year			% change		
Area	2015	2016	2017	2015-2016	2016-2017	2015-17
Coventry (City)	344,300	353,200	360,100	2.6%	2.0%	4.6%
Warwickshire (total)	555,200	559,000	564,600	0.7%	1.0%	1.7%
North Warwickshire	62,800	63,200	64,100	0.6%	1.4%	2.1%
Nuneaton & Bedworth	126,600	127,700	128,700	0.9%	0.8%	1.7%
Rugby	104,500	105,300	106,400	0.8%	1.0%	1.8%
Stratford	122,400	123,300	125,200	0.7%	1.5%	2.3%
Warwick	138,900	139,500	140,300	0.4%	0.6%	1.0%

Figure 5: ONS population and growth by District

ONS 2014-based projections suggest the population of the county of Warwickshire is

projected to increase by an overall 11.1% from 2016 to 2039, lower than the equivalent national increase of 15.0%. However, this masks considerable variation when looking at broad age bands:

- 0-14 years expected growth by 4.9% between 2016 and 2039;
- 16-64 years expected growth by 2.1%;
- 65+ years expected to increase by almost half (49.0%); and
- 90+ years is expected to increase substantially.

	2016	2039	Change	% Change
North Warwickshire	63,229	66,184	2,955	4.7%
Nuneaton & Bedworth	127,019	139,012	11,993	9.4%
Rugby	103,815	121,506	17,691	17.0%
Stratford-on-Avon	140,411	157,505	17,094	12.2%
Warwick	122,276	134,076	11,800	9.7%
Warwickshire	556,750	618,456	61,706	11.1%

Source: ONS, 2014 Population Projections

Figure 6: Warwickshire County Council - ONS 2014 population projections

Although age profiles for NHS Warwickshire North CCG and NHS South Warwickshire CCG are broadly similar there is a greater proportion of residents aged between 0-19 (23%) in NHS Warwickshire North CCG and a greater proportion of residents aged 70 years or over (16%) in NHS South Warwickshire CCG. The age profile for NHS Coventry and Rugby CCG is comparatively different due to the large student population residing in Coventry City; 56% of residents are aged 20-59 but the greatest proportion of residents are aged 20-29 years.

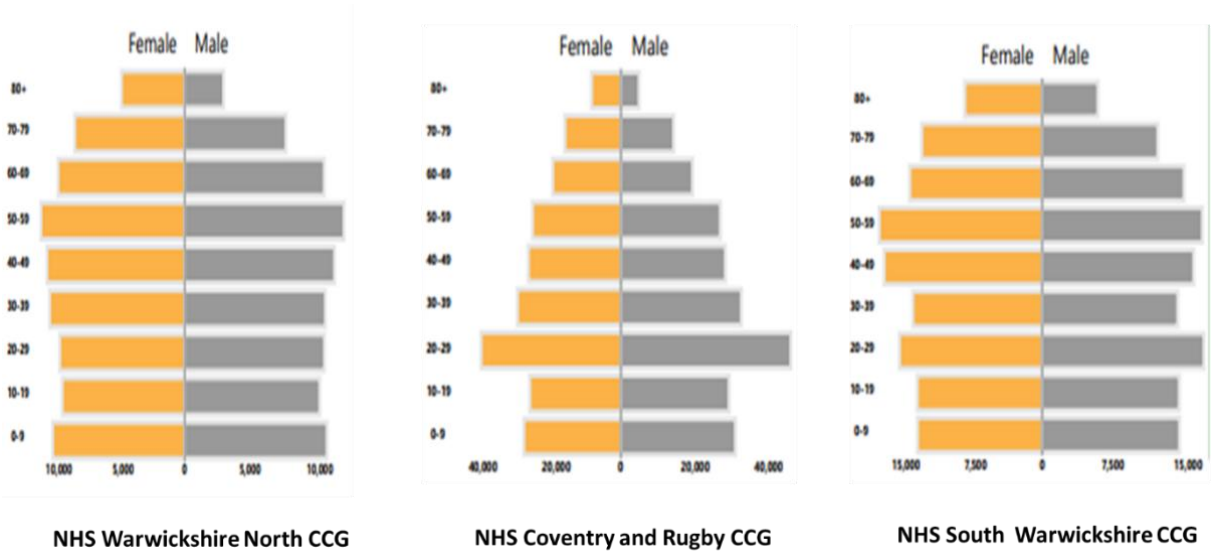

Figure 7: Population Profiles for each CCG

Coventry is one of the fastest growing local authority areas in recent years due to more births than deaths and growing migrant and student populations (attending the two local universities). The number of full time students at the universities has doubled during the last 10-15 years. The growth in over-65s is expected to accelerate and outpace other groups within the next 10-15 years. The city is diverse with around one third of the population and just under half of school aged children from minority ethnic groups. It is a relatively deprived city, ranking 55th out of 326 local authority areas and with significant differences between wards. Almost a third of the children live in low-income families.

Life expectancy is lower than the national average though similar to other areas with the same level of deprivation. There is an inequality gap between the least and most deprived areas, with a difference in life expectancy of 9.4 years for men and 8.7 years for women. The city has higher rates of premature deaths (under the age of 75) from cardiovascular disease, cancer and respiratory disease.

Rugby residents are predominantly in the 'white British' ethnic group and account for approximately 84% of the population (2011 data), and just over 1 in 10 of the population recorded as being born outside of the UK. The variation between wards of most vs least deprived is 5.7 years lower life expectancy for men and 4.0 years life expectancy for women.

South Warwickshire has an older age profile with its 65+ years population size significantly larger than that of both Coventry & Warwickshire as a whole, and nationally. Although its total future population growth is significantly lower, its 65+ years population's growth will be significantly higher than that of both Coventry & Warwickshire as a whole and nationally by 2035. This raises a considerable financial challenge with fewer working age people in the CCG area and increased adult health and social care responsibilities associated with an aging population.

Warwickshire North is an extremely diverse locality, with some neighbourhoods experiencing high levels of deprivation, some with high numbers of BME communities, and several new housing developments alongside more traditional urban town and rural village communities. Like South Warwickshire, both Nuneaton & Bedworth and the North Warwickshire Districts have significant numbers of older people as a proportion of their communities which is significantly larger than that of both Coventry & Warwickshire as a whole and nationally. Its total future population growth is significantly lower but its more rapid growth in those over 65 years will be significantly higher than that of both Coventry & Warwickshire as a whole and nationally by 2020. This raises a considerable financial challenge with fewer working age people in the CCG area and increased adult health and social care responsibilities associated with an aging population.

7. Local health needs

The map which follows shows the index of multiple deprivation (IMD) for the STP area. The IMD in 2015 was 19.87 against a national average of 21.67.

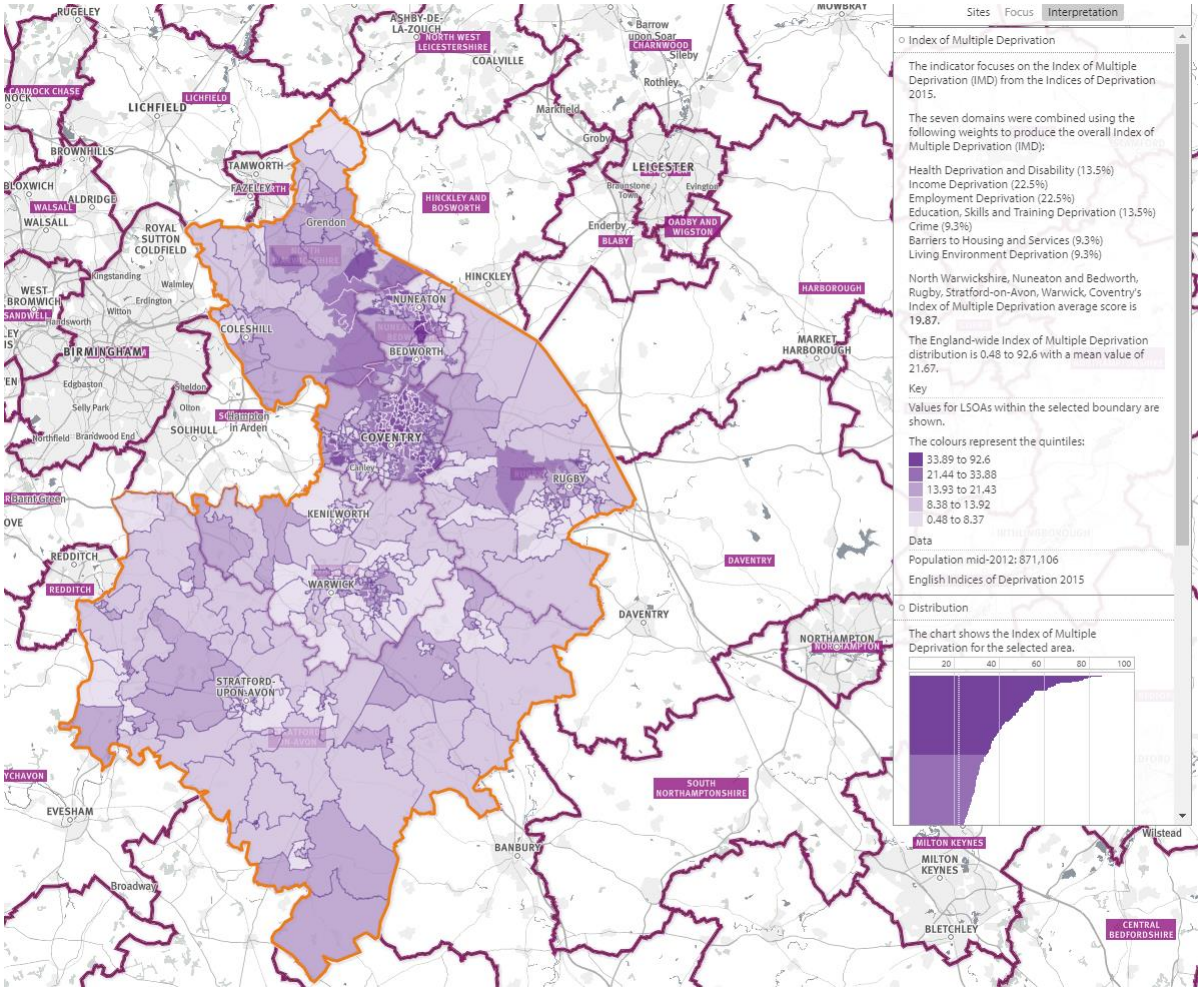

Figure 8: Index of Multiple Deprivations Coventry & Warwickshire

In 2017 a new approach was agreed by the Warwickshire Health & Wellbeing Board, with the focus of the JSNA moving from a theme-based to a Place-based approach reflecting the urgent need for more localised health intelligence. The chart below highlights for the whole of Coventry & Warwickshire some of the specific challenges facing the commissioners currently in addressing health outcomes for patients, benchmarked against national average.

The three CCGs have worked hard individually and together with partner organisations to manage the issues causing these inequalities. However, progress and pace could be improved through increased joined-up working. A more coherent approach to the planning and commissioning of services would help them become more effective and give them a better chance of achieving their objectives more rapidly.

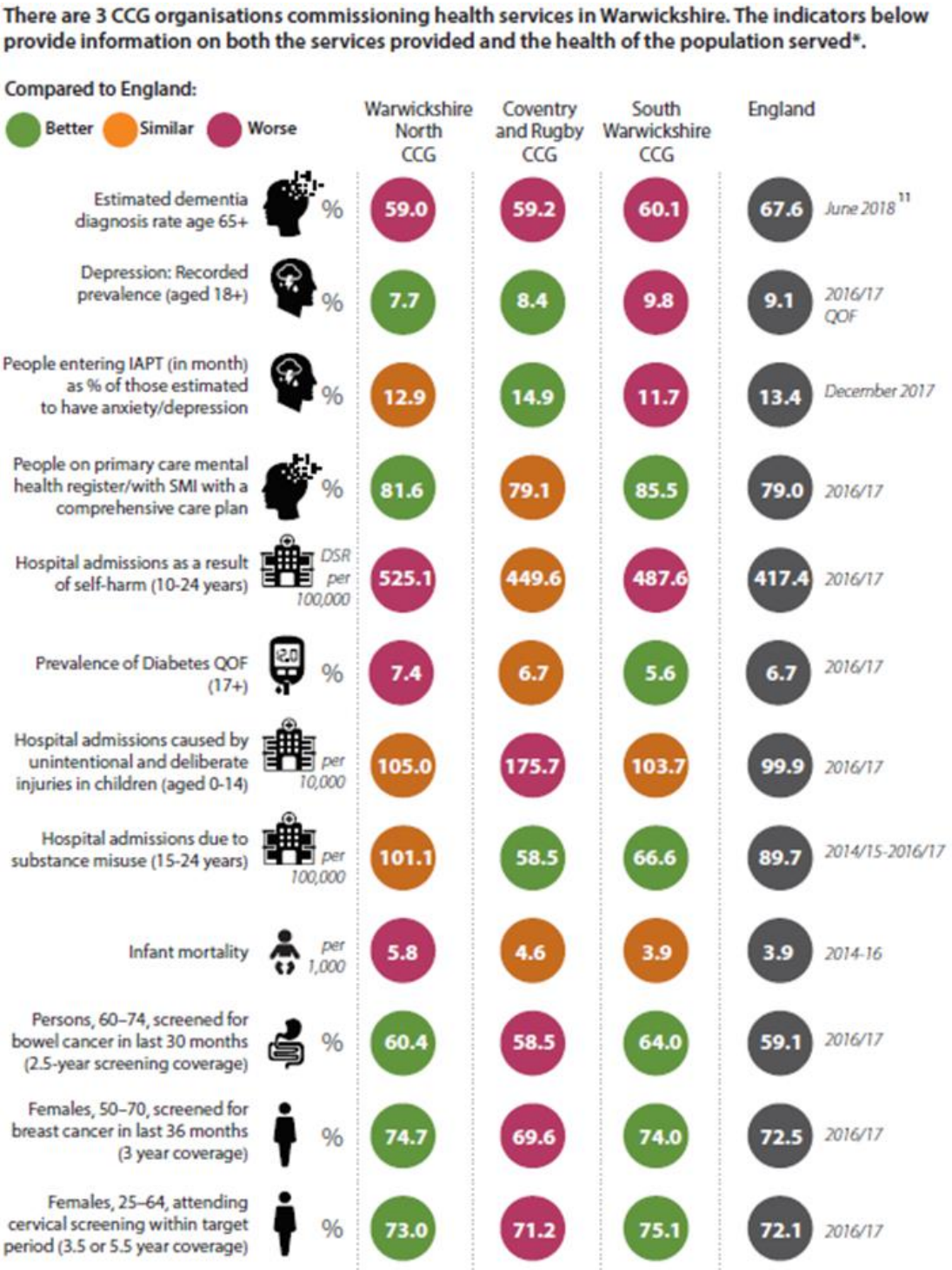

Figure 9: Challenges in health outcomes across all three CCGs

8. Sustainability and Transformation Partnership

In 2016, the Government asked NHS organisations and local councils to formalise their working relationships by forming STPs to deliver NHS England's Five Year Forward View at a local level. The LTP now builds on the Five Year Forward View to completely transform local health and social care across the NHS in England.

This can only be achieved if everyone who has a stake in health and social care - the NHS, Local Authorities, the voluntary sector and other public sector agencies - work together to

achieve change. This change is about providing better quality care, improving health, social care and wellbeing services and making sure that services can be delivered in a sustainable way.

Other than the three CCGs, the members of the local STP 'Better Health, Better Care, Better Value' Board are:

- University Hospitals Coventry & Warwickshire NHS Trust (UHCW)
- George Eliot NHS Trust (GEH)
- Coventry and Warwickshire Partnership NHS Trust (CWPT)
- South Warwickshire NHS Foundation Trust (SWFT)
- Coventry City Council
- Warwickshire County Council
- Healthwatch

The local providers have recently joined together in a Provider Alliance in order to improve patient pathways and reduce duplication in local service provision.

One of the main aims of the STP is to create more effective and efficient organisations, releasing a greater proportion to be spent on frontline services, to the greater benefit of patients. The ambition is to strengthen the voice of commissioning, improve the quality of services across the whole system, meet financial targets and be a stronger commissioner to match local provider partners.

A number of high level goals can be realised, at least in part, by the proposal to change. For example:

- More effective system management underpinned by comprehensive information system;
- More effective and efficient commissioning processes with less duplication;
- Greater focus on outcomes based commissioning;
- Better value through improved efficiency and reduced costs of commissioning function;
- Simpler and more effective governance of commissioning and decision making;
- Stronger service transformation approaches, decommissioning and re-commissioning;
- Aligned budgets (as a minimum) and agreed risk share arrangements.

9. Primary Care Networks

One of the key challenges general practice has faced in the past is the lack of a single, representative provider voice to engage in system level strategic planning and decision making. CCGs have improved this but still not managed to achieve a single voice of general practice. This has led to a perception of lack of representation and influence of general practice at a strategic level.

Nominated GP leaders have worked closely with individual GP contractors, local LMC and GP Federations, to develop a mechanism for securing the One Voice of General Practice. This development provides one aspect of the foundation for future PCN Clinical Directors to play their crucial role in shaping and influencing the ICS and in ensuring that general practice feels fully engaged.

Member practices have already formed geographically aligned Primary Care Networks

(PCNs) typically serving natural communities of around 30,000 to 50,000, though some are significantly larger reflecting local conditions. They will now progress through the NHSE maturity matrix for PCNs and identify population health priorities, including focused action to reduce variation, and extend the range of services available in out of hospital settings.

The developing Primary Care Strategy will aim to ensure that the PCNs in each of the four Places can:

- Co-ordinate out of hospital care.
- Facilitate and promote peer review and sharing of good practice
- Provide additional resilience
- Develop arrangements to join up extended hours
- Improve outcomes for patients by delivering the seven mandated national service specifications contributing to NHS Long Term Plan
- Innovate and collaborate to deliver system benefits
- Utilise investment in new roles to expand general practice workforce
- Support PCN Accountable Directors
- Agree an approach across Coventry and Warwickshire to achieve sustainable GP one voice within the ICS and at Place.

10. Delivery at Place

The Coventry & Warwickshire Health and Wellbeing Place Forums led by local authorities and working with all system partners have developed a model for the future of health and care for the population in Coventry and Warwickshire. They also agreed that within this area there would be four “Places”; these are Coventry, Rugby, Warwickshire North and South Warwickshire.

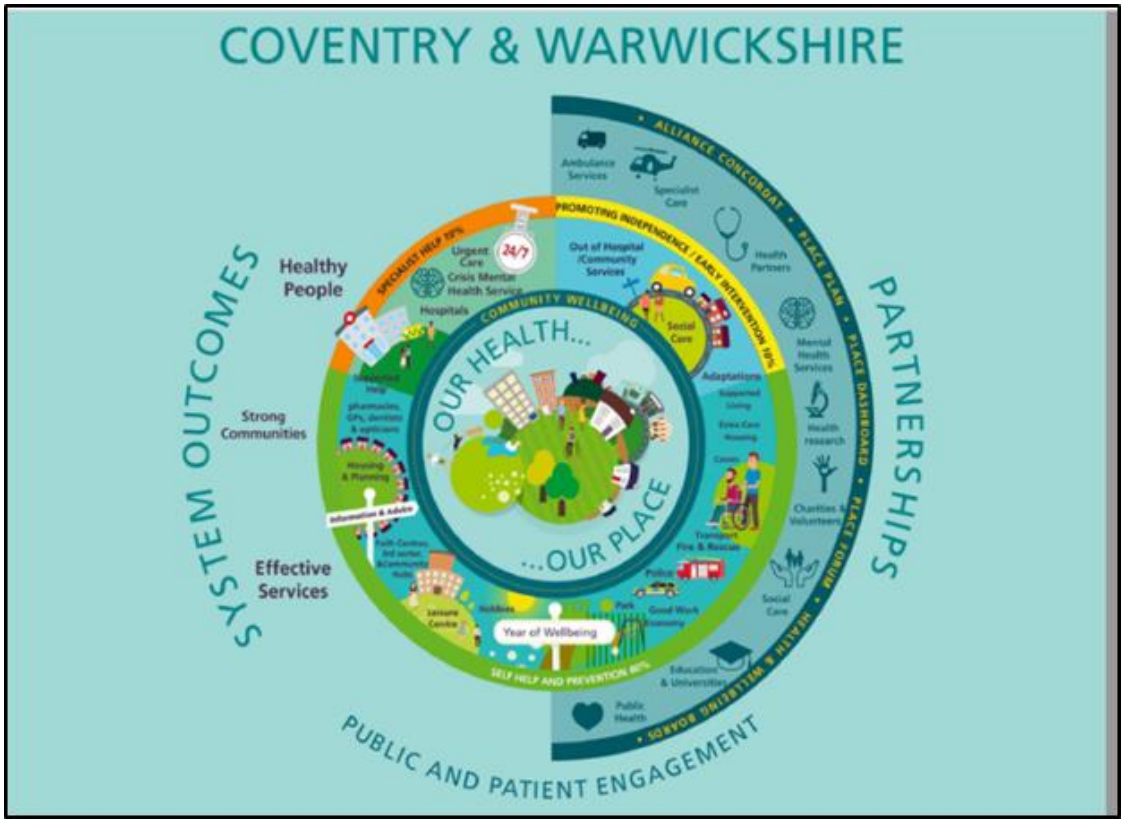

Figure 10: System of care

This model puts people at its heart and builds the system around them. It places much more emphasis on what the system will offer to people around promoting independence, early intervention, self-help and prevention, as this is where the most beneficial and long-lasting outcomes and positive impacts on health and wellbeing can be made. The new model looks to move services closer to where people live, removing some of the barriers to access. It helps to remove unnecessary trips to hospital and the stress that goes with it i.e. parking, appointment times. Finally, it builds on existing partnership working by bringing those commissioning and providing services into even stronger alignment.

In order to best support this new model, there need to be changes to how services are prioritised, planned and commissioned. There needs to be a move away from an income-driven commissioning style, where local providers compete for CCG resources, and a move to an outcomes-based commissioning approach. This means focusing less on paying for performance based on targets and processes, and more on the impact that services have on the health and wellbeing of people living in Coventry and Warwickshire.

Coventry and Warwickshire CCGs have agreed a model of care (depicted in the diagram below). These contracts require community providers to organise their community service offer around GP registered patient lists of around 30k - 50k populations, and to establish integrated teams working in collaboration with general practice and social care.

The action taken to implement Out of Hospital care provides a solid foundation for breaking down historical barriers between primary, community and social care services, and for providing assessment and support for 'higher risk' patients to remain independent later in life. This is achieving system benefits and responding to the requirements of the NHS long term plan by establishing an Integrated Care System with general practice at its core.

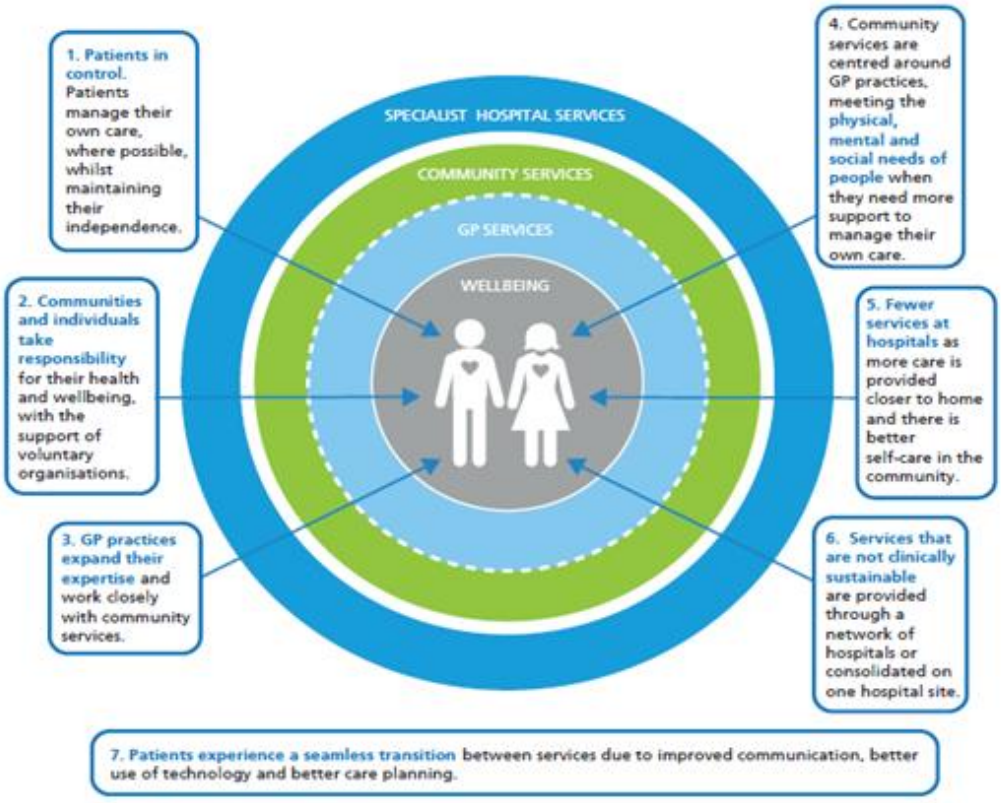

Figure 11: Integrated Care system model

11. Vision

Throughout the engagement with key stakeholders across the STP area, we have learnt that the following objectives are consistently important to them in the CCGs pursuing a single commissioning voice:

- Overall improved health and better outcomes for patients;
- A more sustainable local NHS;
- Better integration of provision and commissioning at Place
- Better integration with the local authorities, especially for social care and preventing poor health outcomes;
- Consistency for patients;
- Ensuring that all patients can access the same high quality service, regardless of where they live in the area;
- A strong and strategic NHS commissioning voice to match that of the provider organisations and local authority;
- A larger and stronger pool of clinical expertise; and
- Building on the existing partnerships the three CCGs currently have.

While finalising proposals, feedback from staff and stakeholders recognised that 'Place' is a key issue. The area of Coventry and Warwickshire is made up of many different natural communities and a key consideration will be how a new organisation can respond to that, whilst still delivering high quality services and addressing and reducing health inequalities.

12. Integrated Care Systems

Despite the legislative framework moving increasingly towards a quasi-competitive market, the policy objective in recent years has been to increase integration and a statement that ICSs will effectively end the purchaser / provider split, bringing about integrated funding and delivery for a given geographical population.

The LTP is clear that local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere. The most recent definition describes their function as

> *"… bringing together local organisations to redesign care and improve population health, creating shared leadership and action."*

In an ICS, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering standards, and improving the health and wellbeing of the population they serve. For example, ICSs are expected to improve health and care by:

- Supporting the coordination of services, with a focus on those at risk of developing acute illness and being hospitalised;
- Providing more care in a community and home-based setting, including in partnership with council social care, and the voluntary and community sector;
- Ensuring a greater focus on population health and preventing ill health;
- Allowing systems to take collective responsibility for how they best use resources to improve health results and quality of care, including through agreed cross-system spending totals.

As the national direction of travel moves away from competition and toward collaboration and integration, commissioners and providers will work more closely together making shared decisions. This will necessitate a different type of commissioning organisation, that aligns strategic commissioning functions to a system level, and tactical commissioning activities to a place level, integrated with provision.

The LTP outlines that:

> *1.51.* ***We will continue to develop ICSs, building on the progress the NHS has already made. By April 2021 ICSs will cover the whole country****, growing out of the current network of Sustainability and Transformation Partnerships (STPs).*
>
> *ICSs will have a key role in working with Local Authorities at 'place' level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health (other than for a limited number of decisions that commissioners will need to continue to make independently, for example in relation to procurement and contract award).*
>
> *Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area.*
>
> *CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.*

Developing the model outlined above will be a continuous journey, with many achievements and small milestones along the way. There are three major stages as outlined in the figure below. These major stages are:

A. **Current:** This first describes the current position and the progress already made within the STP system.

B. **Greater alignment:** The second describes the proposed next step and includes greater alignment between the CCGs (through the bringing together of functions, leadership and governance), alongside greater alignment of the appropriate commissioning activities to integrate with providers at each Place.

C. **Integrated care at system and Place level:** the third describes a foreseeable end-state

D. **Legislative changes**: to underpin local requirements but currently unclear. Proposals for possible changes to legislation were published on 28th February 2019. The earliest time for legislative change is 2022 and CCGs have been encouraged to move forward with implementing the LTP and not wait for legislation.

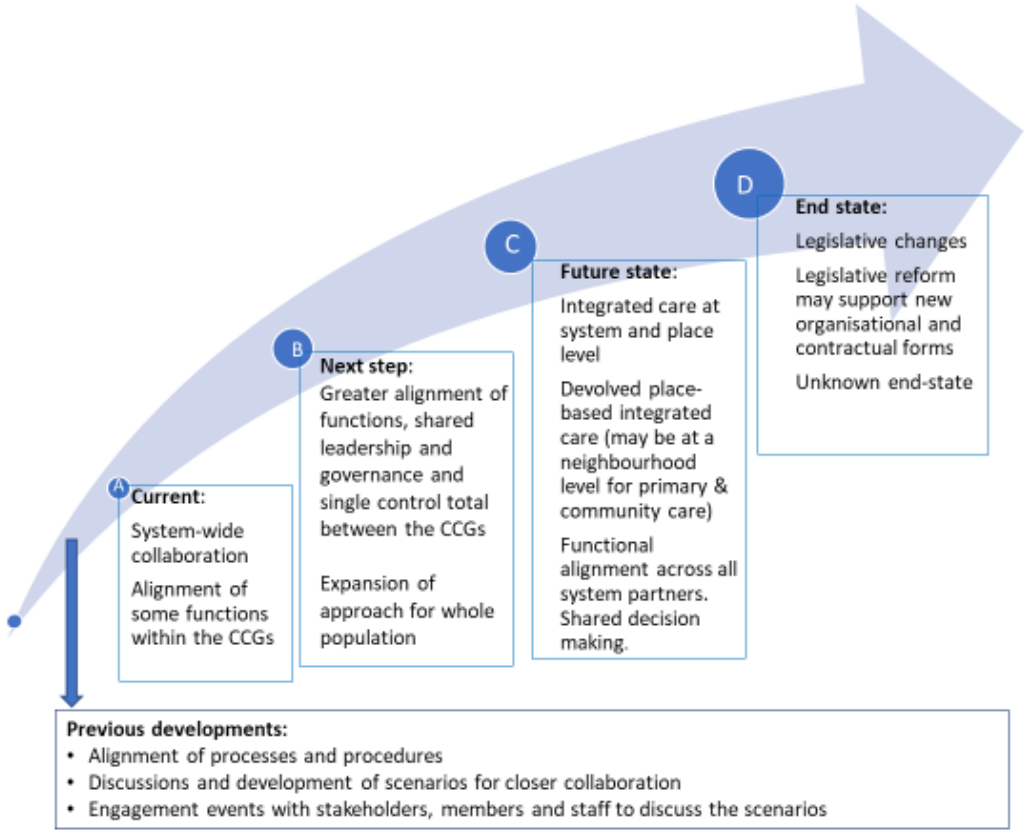

Figure 12: Major stages in moving to strategic commissioning

13. Future arrangements

There is a need to establish appropriate governance arrangements with transparency over where decisions are made when the change in structure is being implemented ahead of any legislation change. Shared management structures have demonstrated many advantages to date, including greater capacity and resilience, economies of scale and an enhanced skills base. The move to joint working and shared responsibility helped those CCGs who were currently struggling to tackle common issues with NHS providers or social services.

The benefits of aligning the boundaries of NHS commissioning areas with existing administrative boundaries at other levels are widely acknowledged. The proposed boundary is aligned and coterminous with both the existing Local Authorities and CCGs. There is no requirement to adjust boundaries or change the relationship of any GP practices to the developing PCNs.

The four Place health delivery systems are coterminous with City, District and Borough Council boundaries and the four groups of PCNs. Local Providers focus on delivery of services to their Place-based populations and, in the case of UHCW, provide some tertiary services to the whole population.

14. Expected benefits of greater alignment

Greater alignment of the health and care organisations will allow creation of a health and social care system that works better for patients and their families and which makes best use of scarce resources. Through minimising the structural barriers that exist between organisations

there is removal of competing priorities of individual organisations and development of aligned objective to improving the quality of health services across the whole of the ICS.

The ultimate goal of this greater alignment is to improve the health of the population, provide better quality care for patients, improve ways of working and return the system to financial balance, by a more effective and efficient use of assets and resources. This will be achieved through transforming clinical services across both primary and secondary care, and also improving organisational alignment and system performance across other areas, including shared functions and shared governance.

There is no technical reason as to why the benefits outlined above cannot be achieved by three separate organisations. However, the practicalities of this arrangement, and learnings from other systems, suggests that this would be extremely difficult to achieve. Without a single leadership team, it will be challenging to achieve the transformative change required to improve the quality of care provided, whilst ensuring financial stability to the system.

This is supported by a wealth of learnings from other systems, where organisations (both commissioners and providers) have attempted to collaborate but where separate leadership has created material, and in some cases insurmountable, barriers to alignment.

Alignment will have, a positive impact on financial stability, through:

- Reduction in duplication – the appointment of joint/single roles will realise savings
- More efficient use of resources across the system
- Improved relationships across the total Coventry and Warwickshire footprint
- Aligning the financial objectives of all organisations removes incentives to act in the interest of individual organisations and encourages activity which benefits the entire system.

15. Current progress

A temporary, dedicated transition team has been convened to manage the transition to a future state, develop and implement a detailed plan e.g. communications, risk and issues and management.

We are confident that the proposal follows a natural progression, building on joint working arrangements and collaborations such as:

- Lead commissioner contract arrangement/joint clinical commissioner groups
- Better Care Fund arrangements through the *Better Health, Better Care, Better Value* Partnership
- Hosted team arrangements
- System Resilience Groups/A&E Delivery Boards

Furthermore, there are already in place some of the following shared functions across two or more of the existing CCGs:

- Single senior management team in two CCGs
- Committees in common e.g. all Governing Body committees included the Governing Bodies of two of the CCGs, but with the exception of the Primary Care Committee
- Joint Strategic Commissioning Committee
- Individual Funding Requests

- Clinical Policy Group.

The strategic delivery plan across the three CCGs is set out in the table below:

Programme	Deliverables for 2019/20	By
Strategic Commissioning	Strategic Framework for the C&W HWB partnership	30 September 2019
	Strategic Commissioner Strategy & yr1 commissioning intentions (including financial strategy)	30 September 2019
	Agreed governance and reporting for strategic commissioning team	30 June 2019
	Strategic Commissioning Process for MCYP; Planned Care; and MH	Throughout 2019/20
	Develop the strategic commissioning clinical leadership function/s	30 June 2019
	Establish an assurance framework that can be used to inform readiness of Place for ICP contract	30 September 2019
	Undertake a baseline assessment of readiness and work with the Places (both provider and delivery commissioning) on a development plan that enables the progression to an ICP contract	31 November 2019
	Develop the system 5-year plan	Autumn 2019
Place Based Transformation Programme	Develop Place based commissioning transformation resources focused on priority areas – MH; Frailty; Planned Care; Maternity and Paediatrics; CIP/QIPP/Value Boards	31 May 2019
	Support the delivery of Place Based 5 year plans	30 June 2019
	Develop Commissioning at Place transformation and continuous improvement methodology with Provider Alliance	30 September 2019
	On behalf of the 4 Places deliver system wide enabling programmes	Throughout 2019/20
Place Based Governance	Develop, for each Place, an agreed Governance mechanism governance for reporting into existing CCGs for 2019/20	31 May 2019
	Ensure governance enables effective participation in the ICS development and enables CCGs to deliver statutory responsibilities	31 May 2019
	Design governance for place-based commissioning	31 December 2019
Population Health Management	System wide clinical leadership development – stage 1	31 March 2020
	Baseline assessment of analytical capacity and capacity for PHM	31 May 2019
	Develop the C&W methodology/approach in line with regional approach and obtain agreement with BHBCBV Board	30 June 2019
	Develop PHM capacity and capability resources in line with the regional approach	31 March 2020
Primary Care Transformation Programme	Mechanisms in place for NHS organisations in each place to work with PCNs	30 June 2019

Figure 13: Joint development plan

16. Future aspects of working together in Place

The move towards system and Place working is intentionally blurring the commissioner/provider split in the NHS and integrated care provider partnerships at Place will in future do some commissioning. This is recognised in many developing ICS systems across England.

By improving alignment with providers, commissioners will be better able to deliver large-scale service and clinical transformation projects across acute, community and primary care, which benefit the whole system rather than individual care settings. The diagram below shows how this alignment would work.

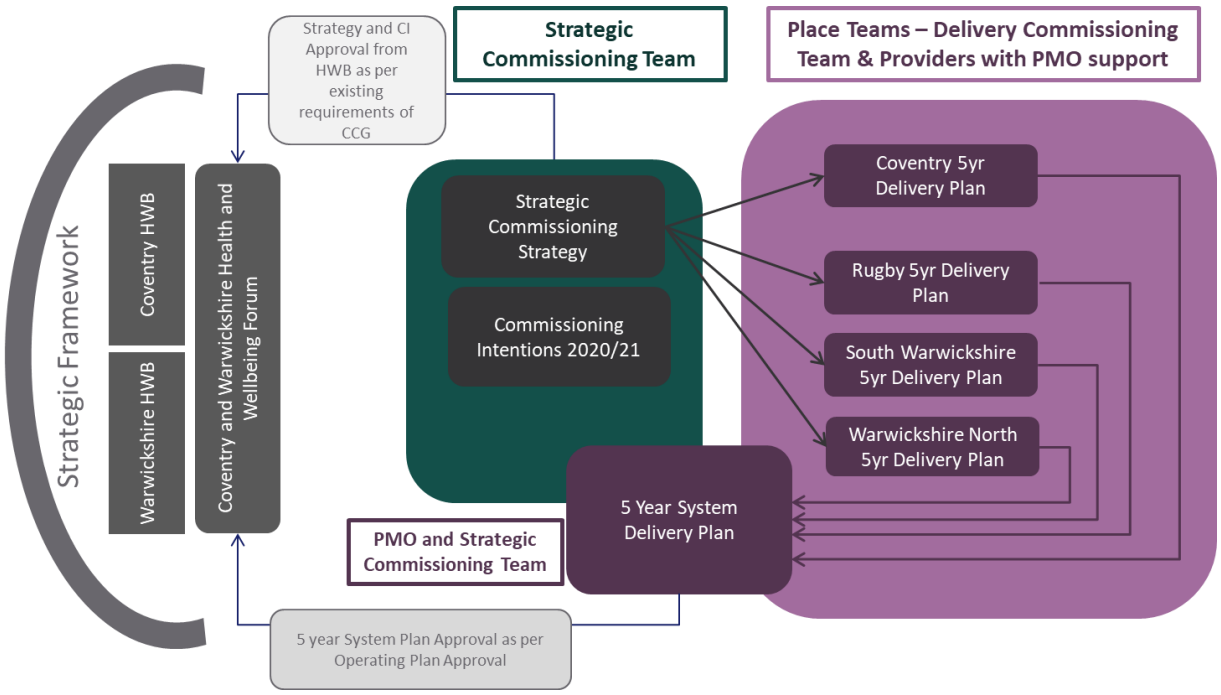

Figure 14: Strategic map

By streamlining commissioning, it will also:

- Remove duplication of functions to enable resources and assets to be used more effectively;
- Reduce misalignment, divergent priorities, and conflicts, which waste unnecessary time and resources;
- Allow the sharing of approaches, capability and best practice with one another.

Furthermore, the LTP, supports the aspirations of Place-based care by committing to the creation of Integrated Care Systems (ICSs) by 2021. The collaboration is a first step on this trajectory, and one that will importantly lead to considerable benefits both in terms of the quality of care and the overall financial stability of the local system in its own right.

17. Financial position

CCGs are required to comply with NHS England's rules on financial performance. Each year, CCG financial plans are checked to make sure they comply with national business rules.

In this financial year (2019/20), the financial positions for each CCG are shown in the table. The combined Coventry and Warwickshire financial plan is an overall deficit of £15m (1.2%).

	2019/20						
	Programme	Running Costs	Primary Medical	Total Budget	In-Year Surplus	Cumulative Surplus/Deficit	
	£m	£m	£m	£m	£m	£m	%
Coventry & Rugby CCG	647.9	10.3	71.2	729.4	0.4	6.4	1.0%
South Warwickshire CCG	354.5	5.8	38.4	398.7	1.9	-3.4	-1.0%
Warwickshire North CCG	252.3	4.0	26.4	282.7	0.0	-18.0	-7.1%
Total C&W Commissioners	**1254.7**	**20.1**	**136.0**	**1410.8**	**2.3**	**-15.0**	**-1.2%**

Figure 15: Financial position 2019/20

CCGs have received confirmed revenue allocations for 2019/20 and 2020/21 and indicative allocations for 2021/22 to 2023/24 setting out expected growth. Should a decision be taken to move to single Commissioner the allocations for each 'Place' would be based upon the published allocations, providing the sum of these does not exceed the single allocation notified to the new CCG.

A process has commenced to identify the Rugby share of the Coventry & Rugby allocation based upon current expenditure and a fair share of any uncommitted reserves.

CCGs need to show how a recurrent 20% reduction in running costs will be achieved in 2020/21, releasing resource to each Place. The CCG Running Costs Allowance is based on a standard national amount per head of population and for 2019/20 amounts to £20.1m for the three CCGs. This amount will not change if the CCGs merge.

18. Stakeholder engagement

The Health and Social Care Act 2012 clearly sets out a legislative requirement for NHS Clinical Commissioning Groups to involve their stakeholders at an early stage and throughout change programmes, at varying degrees. It is important that this legislation and guidance is noted, to avoid any future legal challenge or democratic scrutiny, both of which can be costly in terms of time and money. It must also be ensured that due and proper regard is given to the Public Sector Equality Duty, as set out in the Equality Act 2010.

The vision, priorities, and ways of working, must be shaped, conveyed and implemented through an on-going relationship with all stakeholders, based on mutual respect and openness. Efforts will be made to ensure that partnerships are sustained, well managed and transparent.

There is already a very strong commitment to public engagement and stakeholder involvement, demonstrated by the care taken in ensuring that there are opportunities for local people to influence decision making, and appraisal of the various scenarios. An effective engagement approach will be maintained going forward, based on the existing communications and engagement strategies for all stakeholders. This is possible due to the ability to maintain local structures that allow for a more distributed model of leadership and a focus on local priorities.

Those charged with the authority to set the direction for clinical commissioning are local GPs as is articulated in the CCG Constitutions. GPs are connected to the NHS and see every aspect of it; they are also connected to their local populations. Their input into the process of how to get more from local NHS clinical commissioning is critical to achieving the ambitions set out.

The members and governing bodies of all three CCGs have been informed and involved from the outset and contributed to the planning at each stage. The Governing Bodies confirmed this as the correct strategic direction of travel, but like other stakeholders, there are issues that have been raised (see below). These views and insight will be more important than ever during transition towards a new model and need to be taken into account. Stakeholders have so far raised issues that need to be discussed during the programme of involvement and used as the basis for further conversations that will influence and inform future decisions.

Issues raised for discussion included:

- Need to retain patient-focused pathways of care.
- The role of a single commissioner in an ICS and links to the new PCNs and Place.
- Delivery of a single Commissioning Voice.
- Clarity on the financial impact and management across Coventry and Warwickshire as a whole and at Place.
- How NHS England deadlines for merger applications fit with the need for local engagement and democratic processes.
- Maintaining good relationships at all levels with hospitals and other health and care providers.
- Clarity on the combined vision and priorities for the new organisation, not just its size and shape.
- The need for consistent commissioning strategies across the Coventry & Warwickshire footprint delivering localised implementation at Place.

19. Stakeholder events

Some scenarios were developed to determine the best way of commissioning health services going forward, making the most of the CCGs resources and working more closely with providers and the community and voluntary sector. Stakeholder events were held with staff, representatives of the GP membership, the CCG governing bodies and key stakeholders, including representatives from patient groups and the community and voluntary sector, as well as colleagues working in health and social care.

In the period since December 2018 there have been a number of briefings and engagement events with staff, Members and Governing Bodies. Other events have also been held with key stakeholders between March and May 2019.

The purpose of the engagement activity was to bring together a wide range of key stakeholders from across Coventry and Warwickshire, including colleagues working in health and social care, voluntary and community organisations, councillors, carers and patients and their representatives with the aim of:

- Providing clarity that this piece of engagement was specifically around the future of health commissioning as it pertains to meeting the needs of a future integrated care

system for Coventry and Warwickshire.

- Giving attendees some background information and putting things in context to help them understand why we are considering changing health commissioning.
- Capturing their initial thoughts and reactions to this information to input into the case for change document, due to be presented to the CCG governing bodies in late May 2019.

These events were not:

- A platform to persuade people of our thinking; it was a listening exercise as part of the engagement process
- Aimed at the wider public; rather, they were targeted and focused events with CCG staff and membership, and representatives from various key stakeholder groups from across Coventry and Warwickshire
- A platform to make decisions but a chance for people to further inform thinking.

A wide range of stakeholders were invited to the events. To ensure that the stakeholders were fully representative, we took into account the demographics of our population, previous engagement equality findings and recommendations in how to engage seldom heard and protected characteristic groups.

To ensure there was representation from across Coventry and Warwickshire stakeholders were identified and invited to nominate representatives to attend the events. These external stakeholders included:

- Patients and patient representatives – individuals who had contributed to previous engagement activities, including underrepresented groups of people identified as part of other wider communications and engagement strategies
- Voluntary and community sector representatives including those representing underrepresented groups
- MPs and local Councillors
- Both local Healthwatch organisations

Those who were unable to attend any of the events were offered the chance to contact the team to share their views or request a link to an online survey, although to date no such requests have been received.

Governing bodies

The three CCGs' governing bodies were given an opportunity to feed into the case for change during a governing body development session. Following a presentation to provide background and context, a series of questions was asked. Responses and feedback were captured via an online tool (mentimeter.com).

Members

The same information was presented to each CCG's membership and feedback was captured using an online tool (www.mentimeter.com) where possible. For NHS Coventry and Rugby CCG, CCG representatives attended a Protected Learning Time (PLT) event for the Coventry membership, and a Delivery Group meeting for Rugby.

NHS Warwickshire North CCG holds monthly membership meetings and the April meeting was used to deliver a brief presentation and then capture feedback using the same online tool.

NHS South Warwickshire CCG conducted a meeting with their membership at a Members' Council engagement session in March 2019. One of the key themes from this meeting was that a "larger, stronger GP voice" needed to be added to the assessment criteria, which was agreed.

Local health and wellbeing leads

Letters were sent to the Chief Executives of all the local providers, as well as leaders for local GP federations/alliances and Local Medical Committee Chairs, Deputy Chairs and Secretaries. The letters outlined the approach and requested feedback, in writing, to the proposals and timelines, as well as any other feedback or concerns they had.

Staff

NHS Coventry and Rugby CCG and NHS Warwickshire North CCG staff attended an all-staff team brief, led by the Accountable Officer, on 30th April 2019. An update was given on progress since the last briefing in December 2018, then attendees were asked to provide their feedback and views using the mentimeter tool. Likewise, NHS South Warwickshire CCG held an equivalent staff engagement session on 7th May 2019.

Patients

NHS South Warwickshire CCG spoke with members of its 3PG group - comprised of patient representatives, GPs and the CCG Lay Member for Patient and Public involvement. Feedback from this event suggested that the presentation and subject matter were very complex and needed to be simplified for wider audiences. This was adjusted ahead of the stakeholder events. It was also felt that "patient voice" needed to be added to the assessment criteria alongside "larger, strong GP voice" and this was actioned.

20. Criteria for reviewing scenarios

Various scenarios were considered and through the process of the stakeholder engagement these were refined. When asked, out of 174 people, only three (all staff members) said they were not happy/satisfied with the scenarios identified. At the Warwickshire North stakeholder event, only one attendee felt they had sufficient information to respond to this question. In particular, the majority wanted more information on how each scenario would be costed. They also preferred "Don't have enough information" to "don't know", from a wording standpoint.

The initial criteria used by SWCCG with members were subsequently combined with the criteria used elsewhere, with some additions. These were:

- Progress already made towards a single commissioning voice;
- Realisation of possible efficiencies;
- Potential to address the financial challenge; and
- Level of disruption and speed of change.

After adaptation the following criteria were finally used to evaluate various scenarios:

- Improved clinical quality
- More effective use of resources
- Better access to services

- Development of services
- Ease of delivery
- Improved strategic fit
- Meeting training, teaching, research needs
- Improved environmental quality
- Meeting national/regional policy

Broadly speaking, most of those engaged agreed that all the appraisal criteria were important. Improved clinical quality, more effective use of resources and better access to services were agreed as the highest priorities across all engagement sessions, with the remaining options changing depending on the audience. Generally, meeting national and regional policy was seen as the least important criterion for the majority of stakeholders, with improved environmental quality often in second-to-last place.

Using best practice criteria for assessing more general scenarios, members were asked to rank which of these criteria should be prioritised, and whether these should be sensitised for this subject matter, or if anything was missed by using this set of criteria.

21. Stakeholder responses

The key messages which emerged from the engagement programme were as follows (in no particular order of priority):

Support for change

The vast majority of those engaged were in agreement that there was a need for change to both an integrated care system (ICS), and also that health commissioning needed to change to help enable development of the ICS. However, there was some feeling that much of this had been discussed and promised before and not taken hold in various forms including previous iterations of CCGs (e.g. Primary Care Trusts, Strategic Health Authority). So there was some scepticism that it would work this time around, particularly when it came to integrated the health and social care agenda, finances and accountability.

A full merger was the most preferred scenario

At each session most agreed that a full merger made the most sense and would be the best scenario for achieving the objectives set out in the future model of health and wellbeing for Coventry and Warwickshire, though it was widely recognised it would not be an easy, quick or cheap process. Local provider's feedback to date has also been broadly supportive of a full merger.

Joint management team across three CCGs first before moving to full merger

At each session some questions were raised over whether, due to the tight timeframes, there was a possibility of doing a "best of both worlds" approach, which would involve first moving to a joint management team to build the foundation of the new commissioning structure before moving to a full merger.

Building robust "Places" – and not losing local identity – is critical to success

All agreed that success or failure of the health and wellbeing system was dependent on building and supporting strong "Places". Loss of local voice and identity were highlighted as being of large concern when thinking about moving to a strategic commissioning structure.

Involving the local population and their representatives is seen as another critical measure of success

Local people, and those that represent them (whether that be in the community and voluntary sector or elected officials), were eager to be involved as much as possible in the future development of systems to improve the health and wellbeing of the local population. Transparency, openness and the opportunity to feed into and influence planning and delivery were considered of vital importance.

Supporting staff is vitally important

Any change to the status quo will introduce uncertainty, worry and potential changes for staff. All stakeholders agreed the importance of supporting them during any change couldn't be overstated. Understandably, amongst staff groups job security was a chief concern.

"Do nothing" is not a viable scenario

Only one person felt that "do nothing" was a viable scenario. All others considered it was not; either due to pressures from NHS England or for achieving the aspirations of the future model of health and wellbeing for the area.

A full report will be available on the website of each of the three CCGs.

22. Criteria to select final options

OPTIONS			
	1: Do nothing	**2: Single Management**	**3: Full merger**
Criterion	**Three statutory bodies**	**Three statutory bodies & joint commissioning**	**One statutory body**
Improved clinical quality	No change	All the clinical expertise in the STP area would be available to the whole STP area	All the clinical expertise in the STP area would be available to the whole STP area
More effective use of resources	No advantage	More stable arrangement than no change	Stable arrangement.
			Single legal entity.
		Single executive team - loss of some senior posts	Single executive team – loss of some senior posts
Better access to services	No advantage	No advantage	Single voice for strategic commissioning of local services
Development of services	No advantage	No advantage	Single voice for strategic commissioning of local services
Ease of delivery	No change	No advantage	No advantage
		Timeframe 3-6 months	Timeframe 9-22 months
Improved strategic fit	No advantage	Some economies of scale	Maximises potential for economies of scale
			Eliminates commissioning duplication and inconsistent approaches
			Allows single financial and service strategy
			Strong basis for negotiation and approach to STP
Meeting training, teaching, research needs	No advantage	No advantage	No advantage
Improved environmental quality	No advantage	No advantage	No advantage
Meeting national / regional policy	Does not achieve requirement	Joint alignment to STP / ICS	Full alignment to STP / ICS for providers / provider alliance and local authorities to engage with
		Retains three commissioning bodies and three sets of statutory requirements to be delivered	Move from three sets of statutory requirements to one
		No advantage – influence across STP not maximised	

23. Options for the future direction of health commissioning arrangements

As a result of the discussions and consideration of the criteria the following options are set out below for Governing Body consideration:

○ Option one: No change

Three separately accountable CCGs and current, separate management arrangements.

Until recently, each of the three CCGs had separate management teams, planning processes, priorities, budgets, and reporting responsibilities. Within the last two years NHS Warwickshire North and NHS Coventry & Rugby CCGs have shared an executive team and aligned work programmes focussed on the relevant lead acute provider for the CCG. This has enabled some streamlining of staff time involved.

While there are lead commissioning arrangements in place for contracting purposes, providers in the STP area work with the views of three CCGs, as does Warwickshire County Council. Coventry City Council has the benefit of working solely with Coventry & Rugby CCG, though the CCG works with both Local Authorities.

Management and governance arrangements are duplicated. The CCGs have two accountable officers, two chief finance officers, two executive teams and hold two sets of committee meetings in public. But they have three sets of offices, complete all their legal responsibilities separately three times (such as accounts), commissioning plans, production of three annual reports and maintenance of three websites.

Implementing this option would maintain the status quo and would not fulfil the vision of becoming a strategic commissioner nor the development of an ICS. It does not offer any benefit in terms of economies of scale nor deliver the required reduction in costs. It does not improve recruitment and retention and creates the potential to lose clinical leadership and key staff. There would remain three commissioning voices, with potentially divergent associated commissioning priorities. This would appear to duplicate decision making at Place and potentially hinder progress.

This option has therefore been discounted.

○ Option two: Retain three CCGs but with a single management structure

A single joint management team established following the immediate appointment of a single Accountable Officer for the three CCGs with retention of the three existing statutory bodies

In this arrangement, the current CCGs would remain separate organisations that share some staff and structures to help them work more efficiently. This model would deliver marginal benefit in cost reduction in areas such as joint committees or holding committees-in-common to undertake aligned priorities and responsibilities. Each CCG would retain its own constitution, governing body and membership arrangements for all statutory functions. The CCGs would work toward this arrangement by appointing a single Accountable Officer and Chief Financial Officer in the first instance. The timescale for this has already been approved

by the Governing Bodies and recruitment will commence shortly.

Implementing this option would require the CCGs to co-design and implement new non-statutory governance arrangements. Comparing this option to the current arrangements in Option 1, there are no material advantages. Implementing this option would incur little disruption for staff and have no significant impact on the current level of duplication. Meetings-in-common would need to be held in a rotation of the three sets of CCG offices which might disadvantage some stakeholder and public attendance.

○ Option three: Merger of the three CCGs

A single commissioning voice, management team, constitution, and governance arrangements following merger; with a single, joint management team established following the immediate appointment of a single Accountable Officer for the three CCGs up to the date of merger

This option establishes an entirely new CCG, with a single management team, governing body and one set of statutory duties to be delivered, coterminous with the whole STP area and including both Local Authorities. It would provide the foundation of the future ICS and do so within the timeframe required nationally.

The arrangement would be stable, permanent and align to existing local authority health scrutiny and Health and Wellbeing Board arrangements. This alternative would allow more effective partnership work within the STP, including with NHS England, on areas outside of the CCG's scope e.g. specialised commissioning.

Implementing this option would require the early recruitment of an Accountable Officer and a Chief Financial Officer to appoint a single executive team and to design and implement new statutory governance arrangements leading on the merger application to NHSE England and delivery of the merger programme arrangements.

Compared to current arrangements, this arrangement would be significantly more sustainable and substantially reduce duplication because there would be one statutory body, rather than three; a single legal entity for providers, third sector and local authorities to engage with; and a single set of reporting and policy approaches to deliver consistency for the people of Coventry and Warwickshire.

These arrangements would make all the clinical expertise available in the area available to the whole of the area, with the single CCG working together with the recently established Provider Alliance which itself covers those within the STP footprint.

24. Conclusions

1. It is considered that, due to the lack of any demonstrable benefits, Option 1 is discounted entirely.

2. Option 2 is a viable option but fails to deliver a single commissioning voice and retains three statutory organisations and overheads in management and requirements.

3. Option 3 creates a single management structure whilst moving the organisations to full

merger. It gives the best chance of achieving the national target of becoming an ICS by 2021 and delivers the requirements of full coterminosity with the STP area and boundary alignment with the local authorities. It also provides the greatest potential for achieving the financial reduction in management costs required by the NHS Long Term Plan and the ability to develop a strategic commissioning function to support a single co-ordinated approach to the commissioning and delivery of health care at Place.

25. Recommendations

1. That the Governing Body support Option 3
2. That CCG member practices are asked to choose (by voting) either Option 2 or Option 3

26. Delivery timeline

Following the Governing Bodies' decision on the recommended option, planning to deliver the this will continue in the meantime.

The CCGs will proceed to engage with members and stakeholders during the next few months to ensure that the planning is robust. If it becomes clear during the engagement that the preferred option is not sustainable and/or does not deliver the required benefits a further report will be brought back to the Governing Bodies with a revised recommendation and next steps.

If Option 3 (Full Merger) is supported there will be a requirement to formally apply to NHS England for formal merger to take place. Annex 1 sets out the NHSE / NHSI criteria for assessing CCG mergers. Whilst there are many other documents that will need to be developed or refined to support the case for change for merger, these criteria will need to be assured within that case. Formal application would be required in September for transition on 1 April following.

In each of the change options (Options 2 and 3), the three Governing Bodies will have a single Accountable Officer and will work towards a single management team. This approach offers clear executive leadership and economies of scale.

There is every intention of retaining strong clinical leadership under changed arrangements and envisage retaining a robust executive function incorporating the Accountable Officer role. However, adjustments will be needed such as determining the required skills and capacity in accordance with NHSE guidance. This would include the establishment of the correct balance of clinical, lay member and executive roles.

It is recognised that clinical leadership has two distant parts; those involved in strategy, governance and accountability (e.g. Governing Body members), and those driving delivery, patient centred care pathways, implementing new evidence, building relationships with clinicians in provider organisations. The approach will be to get the balance between these two roles and ensure those clinicians with the right skills are in the right roles.

In developing the new operating structure, there would need to be decisions on how to establish the function of Clinical Chair and the wider clinical engagement and leadership structures. Since these are well-regarded/trusted mechanisms in each of the existing CCGs

it has significance in terms of continuity. The new leadership will need to finalise the proposals, but the intention would be to agree the core principles with the respective memberships to underpin new arrangements in a merged organisation.

These plans will be firmed up and made available for scrutiny after the final decision on the option is reached. Steps will also be taken to mitigate any risks associated with changes for example using necessary shadow committees/arrangements where committee structures are to be altered.

27. Membership engagement

As set out in the CCGs' constitutions, the memberships of each organisation are required to agree changes to their organisation. The following membership engagement principles will be followed:

- Engagement will continue to build on the clinical led model; where local GPs are at the heart of the conversation, being visible and their presence sustained
- Engagement will have a shared focus for the future, where the goal is to be a strong strategic commissioner
- The arrangements by which GPs are engaged will be flexible and will be able to adapt to small and larger networks
- Engagement with GPs will be supported by a common message, with common materials so that all GPs throughout Coventry and Warwickshire receive consistent, timely and relevant information
- There will be a commitment to using and building upon existing networks for engagement, so that there is minimum disruption to business as usual
- An evidence-based approach will be used
- The overall approach to engagement should be informed by the Local Medical Committees.

28. Future financial management

It is too early to draw together the detail of this plan but there are several components of the financial control arrangements which will be essential in delivering proper stewardship and accountability for public funds in a new structure or new CCG.

These are set out below in such a way which incorporates a transition phase if required:

- ***Audit Committee***: If Option 2 is adopted, jointly agreed terms of reference and holding meetings in common. Robust audit arrangements would be expected to be adopted by a new CCG in order to ensure clear oversight of financial governance.
- ***Chief Finance Officer and Finance Team***: financial planning, management and reporting is provided in-house with AGEM Commissioning Support Unit providing financial systems and transactions support. There is a need to ensure continuity with regard to these arrangements. The appointment of a single Chief Financial Officer will be undertaken prior to the remaining leadership team. The structure and functions of the finance team for the new arrangements will be determined following that appointment.
- ***Financial policies***: adoption of a common set of prime financial policies. These policies would become the prime financial policies for a new CCG. Harmonisation of

the scheme of delegated financial limits used by the individual CCGs would be adopted by a new CCG.

- ***Financial planning***: the three CCGs developed joint working arrangements for the completion of the most recent contracting process. This included common assumptions for financial planning purposes and lead commissioner arrangements for contract negotiation processes.
- ***Financial system/budgetary controls***: the CCGs operate a common financial system (ISFE) and use the business intelligence reporting functionality from ISFE to support budgetary control and financial management. Further work will be undertaken to continue to harmonise detailed working practices to ensure financial control operates effectively under new arrangements.
- ***Internal audit***: Coventry and Warwickshire Audit Services (CWAS) currently provides internal audit and counter fraud services to all three CCGs. CWAS would deliver a jointly agreed single audit plan as approved during any transition phase by each Audit Committee. This approach is expected to facilitate a smooth transition of internal audit arrangements into the first year of a new CCG which may then choose to re-procure internal audit and counter fraud services in future.
- ***External audit***: external audit arrangements would need to be confirmed or procured depending on the option selected.

In the longer term, the establishment of new models of care and structures will see deployment of resources in new settings. In addition, the future commissioning function will continue to evolve, with a wider range of potential partners including local authority and other statutory agencies, and there is an expectation that greater efficiencies will be available over time as these new structures develop.

ANNEX ONE

NHS England tests on a decision in principle for the formation of one CCG[1]

The application procedure for CCGs proposing to merge has been revised in light of the NHS Long Term Plan, and the learning from previous mergers. The revised procedure sets out the legal requirements, and how CCGs should work together to prepare merger applications. The revised procedure builds in benefits realisation from the outset, so that the proposed benefits of joint working and merger (streamlined commissioning across systems, efficiencies, financial savings, etc) are clearly articulated and measured. As CCGs merge and cover larger areas, they will need to show how they will retain local focus and involve members and communities.

In accordance with the legal requirements and the NHS Long Term Plan, NHS England will consider the following criteria in deciding whether to approve a proposed merger:

I. Alignment with (or within) the local STP/ICS

To provide the most logical footprint for local implementation of the NHS Long term Plan, and to provide strategic, integrated commissioning to support population health.

II. Co-terminosity with local authorities

There is a presumption in favour of CCGs being coterminous with one or more upper-tier or unitary local authorities. They should also show how they have/will put in place suitable arrangements with local authorities to support integration at 'place' level (population of between 250,000 and 500,000).

III. Strategic, integrated commissioning capacity and capability

In line with the legal requirements, the existing CCGs must demonstrate that they have/will develop the leadership, capacity and capability for strategic, integrated commissioning for their population. This will include population health management, new financial and contractual approaches that encourage integration, and developing place-based partnerships. In accordance with the legal requirements, the application must demonstrate how any commissioning support services to be procured will be of an appropriate nature and quality.

IV. Clinical leadership

In line with the legal requirements, the existing CCGs must demonstrate how the proposed new CCG will be a clinically led organisation, and how members of the new CCG will participate in its decision-making.

V. Financial management

In accordance with the legal requirements, the existing CCGs must show how the new CCG will have financial arrangements and controls for proper stewardship and accountability for public funds.

[1] Procedures for clinical commissioning groups to apply for constitution change, merger or dissolution NHS England & NHS Improvement April 2019

VI. Joint working

Ideally, a merger should build on collaborative working between the existing CCGs and represent a logical next step from current arrangements. The merger application should show progress on joint working to date and must show how the existing CCGs intend to resource and manage the merger process itself.

VII. Ability to engage with local communities

Assurance is required that the move to a larger geographical footprint will not be at the expense of the proposed new CCG's ability to engage with - and consider the needs of - local communities.

VIII. Cost savings

Where possible, the existing CCGs should show how collaboration and joint working to date has contributed to cost savings; they must also show any further cost savings projected to result from the merger, and when, and how cash released will be re-invested.

IX. CCG Governing Body approval

The merger application must show evidence of approval for the merger by the Governing Body of each of the existing CCG governing bodies.

X. GP members and local Healthwatch consultation

Evidence is required that each of the existing CCGs have engaged with, and seriously considered the views of, their GP member practices, and local Healthwatch, in relation to the merger. The merger application must record the level of support and the prevailing views of each existing CCG's member practices and local Healthwatch, and the existing CCGs' observations on those views.

Abbreviations used in this document

BME	Black and minority ethnic
CCG	Clinical Commissioning Group
CRCCG	NHS Coventry & Rugby CCG
GMS	General Medical Services (contract)
ICS	Integrated Care System
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LTP	NHS Long Term Plan (10 year Plan)
PCN	Primary Care Network (of GPs)
STP	Sustainability & Transformation Partnership
SWCCG	NHS South Warwickshire CCG
WNCCG	NHS Warwickshire North CCG